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COMPREHENSIVE DENTISTRY

MEDICAL HISTORY

Name of Patient: _____ **DOB:** _____

<u>Name of Medication/Drug/Supplement & Dosage:</u>	<u>Purpose/Reason:</u>
_____	_____
_____	_____
_____	_____

Do you require antibiotic prophylaxis prior to dental treatment? Y N
If Yes, Why? _____ Which Antibiotic? _____

Do you have any artificial joints or prosthesis? Y N If Yes, when was surgery performed? _____

Have you had an allergic reaction to any of the following substances or other substances? Penicillin, Sulfa Drugs, Apsirin, Codeine, Morphine, Dental Anesthetic, Latex, Other. _____

Other Medical Information: _____

Bisphosphonates
Have you ever taken bone modifying medications (such as bisphosphonates or denosumab) that affect the bone or prevent bone disease (e.g. Fosamax [Alendronic acid], Zometa [Zoledronic acid], Actonel [Risedronic acid], Boniva [Ibandronic acid], Aredia, Prolia, Xgeva? Y N
If Yes, please list the medication and how long it was or has been taken for. _____

Cardiovascular
Do you or have you ever been told you have any of the following conditions and what date were they diagnosed?
1) Congenital Heart Problems? Y N If Yes, when was it diagnosed? _____
2) Infective Endocarditis or other Heart Infection? Y N If Yes, when was it diagnosed? _____
3) Artificial Heart Valves? Y N If Yes, when were those placed? _____
4) Heart Transplant? Y N If Yes, when was that performed? _____

Sleep Apnea / Snoring

- 1) Have you or anyone in your family been diagnosed with sleep apnea? Y N If so, who? _____
- 2) Do you snore or has someone told you that you snore? Y N
- 3) Do you gasp or have periods of breathing pauses during sleep? Y N
- 4) Do you have difficulty staying awake during the day or fall asleep when you should be awake? Y N

Do you have (or have you ever been told you have or had in the past) any of the following conditions?

High Blood Pressure	Y	N	Tuberculosis "TB"	Y	N
High Cholesterol	Y	N	HIV / AIDS or any other		
Heart Disease	Y	N	immunocompromised conditions?	Y	N
(e.g. angina, coronary artery disease, congenitive heart failure)			Blood Disorders	Y	N
			(anemia, hemophilia, sickle cell anemia)		
Diabetes	Y	N	Kidney Problems	Y	N
(sugar diabetes, blood sugar problems)			Stomach or Intestinal Disorders	Y	N
			(e.g. ulcers, GERD)		
Cancer/Tumors	Y	N	Phobias, Severe Anxieties, Depression or		
Have you ever had radiation, surgery or Chemotherapy to			other psychological Problems)	Y	N
treat cancer?	Y	N	Do you use tobacco?	Y	N
			Drug Addiction?	Y	N
Inflammatory Diseases	Y	N	Have you ever bled excessively after being		
(e.g. arthritis, rheumatism)			cut or receiving dental care?	Y	N
			Have you ever had a heart attack, stroke or		
Alzheimer's Disease	Y	N	coronary bypass operation?	Y	N
			Breathing Problems?	Y	N
Asthma	Y	N	Do you have a pacemaker?	Y	N
			Are you pregnant / think you may be?	Y	N
Thyroid Problems	Y	N	Are you nursing?	Y	N
Epilepsy or Dizzy Spells	Y	N			
Hepatitis or other Liver Disease	Y	N			
Herpes	Y	N			

Please provide details on any conditions which you responded "YES" to above: _____

Are there any other problems or issues about your health that you know of? If yes, please explain: _____

X _____ / _____ Date: _____

Signature of Patient

Printed Name of Patient

Individual updating medical history if not the patient: _____